Washington Health Program™
A Basic Health Plan

Washington Health Program Application

NOTE: Use blue or black ink to complete this application. Your Social Security number (SSN) is voluntary. If you do not provide your SSN, we will assign an ID number to you.

Section 1: Household Information

What language and dialect do you speak? Check here if you need an interpreter ❑			WA Driver License or ID Number*
Applicant's last name	First name	MI	Social Security number	Birth date
Gender ❑ Male ❑ Female	Requesting Coverage? ❑ Yes ❑ No	U.S. citizen? ❑ Yes ❑ No	Receiving Medicaid benefits? ❑ Yes ❑ No
Street address required; **must attach proof** Apt. #	City	County	State	ZIP Code
Mailing address or PO Box (if different from above)	City	County	State	ZIP Code
Home phone number ( )	Other phone number ( )	Do you use tobacco products? ❑ Yes ❑ No	
Marital status (check one) ❑ Single ❑ Legally Separated ❑ Legally Married – Date of marriage:		Are you pregnant? ❑ Yes ❑ No	
Email Address	Do you prefer to be contacted by? ❑ US Mail ❑ Email		

Are you, your spouse, and/or your dependent(s) (up to age 26) currently receiving Social Security Disability Benefits (SSDB)? ❑ Yes ❑ No
If "yes," list them here with dates benefits started. Attach copies of the original and current award letters for each.

Name_____ SSDB entitlement date_____

Name_____ SSDB entitlement date_____

Name_____ SSDB entitlement date_____

Name_____ SSDB entitlement date_____

Are you or your spouse eligible for Medicare (the federal health program for people over age 65 or people who have been receiving Social Security Disability Benefits for more than two years)? ❑ Yes ❑ No **If "yes,"** list them here:

Name_____ SSDB entitlement date_____

Name_____ SSDB entitlement date_____

Name_____ SSDB entitlement date_____

Name_____ SSDB entitlement date_____

Complete this section for legal spouse, only if requesting coverage

Spouse's last name	First name	MI	Social Security number	Birth date
Gender ❑ Male ❑ Female	U.S. citizen? ❑ Yes ❑ No	Receiving Medicaid benefits? ❑ Yes ❑ No		
Do you use tobacco products? ❑ Yes ❑ No	Are you pregnant? ❑ Yes ❑ No			

*If you provide a valid Washington State driver license or identification card number, Washington Health may accept it as proof of residence without you sending a copy of the document.

Section 2: Legal Dependents (If more than four, list on a separate sheet or copy this page)

List your legal dependents that you are requesting coverage for.

1 Last name, first name, MI | Relationship to applicant ❑ Son ❑ Daughter ❑ Other _____

Social Security number | Birth date | Gender ❑ Male ❑ Female | Is dependent a U.S. Citizen? ❑ Yes ❑ No

Is dependent attending higher education out of state? ❑ Yes ❑ No ***If yes, send proof of registration***.

Is dependent receiving Medicaid benefits? ❑ Yes ❑ No

2 Last name, first name, MI | Relationship to applicant ❑ Son ❑ Daughter ❑ Other _____

Social Security number | Birth date | Gender ❑ Male ❑ Female | Is dependent a U.S. Citizen? ❑ Yes ❑ No

Is dependent attending higher education out of state? ❑ Yes ❑ No ***If yes, send proof of registration***.

Is dependent receiving Medicaid benefits? ❑ Yes ❑ No

3 Last name, first name, MI | Relationship to applicant ❑ Son ❑ Daughter ❑ Other _____

Social Security number | Birth date | Gender ❑ Male ❑ Female | Is dependent a U.S. Citizen? ❑ Yes ❑ No

Is dependent attending higher education out of state? ❑ Yes ❑ No ***If yes, send proof of registration***.

Is dependent receiving Medicaid benefits? ❑ Yes ❑ No

4 Last name, first name, MI | Relationship to applicant ❑ Son ❑ Daughter ❑ Other _____

Social Security number | Birth date | Gender ❑ Male ❑ Female | Is dependent a U.S. Citizen? ❑ Yes ❑ No

Is dependent attending higher education out of state? ❑ Yes ❑ No ***If yes, send proof of registration***.

Is dependent receiving Medicaid benefits? ❑ Yes ❑ No

Section 3: Selection **Choose one health plan for your family (check one)**

Annual Maximum Benefit: ❑ Health 75 ($75,000) ❑ Health 100 ($100,000)

An annual maximum benefit applies to all services per member per calendar year. Each year, once you reach the maximum benefit based on which plan you selected when you enrolled, you are responsible for any and all allowed charges.

(continued on next page)

Washington Health Program™

Agreement and Signatures

I understand that:

- By signing this form, I have authorized Washington Health to verify my eligibility information with other state or federal agencies or other third-party sources.
- I must report address changes and changes in my family.
- Washington Health's deposit of my premium payment does not guarantee coverage. The payment will be refunded if I am determined ineligible for coverage.

I authorize my health plan or medical provider to give medical records to Washington Health for the purposes of participation in Washington Health.

I have read and I understand the information provided to me with the Washington Health application. I declare, under penalty of perjury, that the information I have given in this application and the documents I send to Washington Health are true, correct, and complete to the best of my knowledge. I understand that if I or any member of my family, or any person on my behalf, submits false information, my spouse or I may lose coverage, may be held financially responsible for services obtained under Washington Health or additional or past premium amounts due, and may face other penalties and prosecution. Any debt owed to the state may be sent to a collection agency for recovery.

Agreement must be signed by you and your spouse, if legally married.

Signature of applicant	Date	Signature of spouse	Date

Signature of all dependents age 18 and over

Signature	Date	Signature	Date
Signature	Date	Signature	Date

Final Checklist

Please make sure you include the following when submitting your application:

- ❑ Documents showing your name and current street address*
- ❑ Application signed by you and your spouse, if legally married
- ❑ Your completed *Standard Health Questionnaire* (SHQ) for **each family member**
- ❑ The *Permission Form* (available at **www.washingtonhealth.hca.wa.gov**) if you'd like someone else to be able to access your account information, including an uncovered spouse.

Please do not send any payments with your application.

*Unless you provided a valid Washington State driver license or identification card number

Mail to: Washington Health, PO Box 42714, Olympia, WA 98504-2714

Fax to: 360-725-2047

Visit our website for more information at www.washingtonhealth.hca.wa.gov or call us at 1-800-660-9840.

Privacy statement: We will keep your information private as allowed by law. The Washington State Health Care Authority administers Washington Health Program. To see our Privacy Notice, call 206-521-2035 or go to **www.hca.wa.gov**.